California Department of Health Services (CDHS)
Office of Women's Health (OWH)
Women's Health Council (WHC) Quarterly Meeting
September 13, 2006

Meeting Summary

Council Members in Attendance:
Golnaz Agahi, Yali Bair, Bev Ching, Namju Cho, Crystal Crawford, Karen Dalton, Raquel Donoso, Ellen Eidem, Rae Eby Carl, Adele James, Crystal Hayling, Ruth Holton Hodson, Marty Jessup, Adele James, Gail Newell, Luz Alvarez Martinez, Judy Patrick, Marj Plumb, Catherine Quinn, Mily Trevino-Sauceda, Joan Stevie, Alina Salganicoff, Sarah Samuels, Beatriz Solis, Tracy Weitz, Mary Wiberg, Jane Sprague Zones.
Not in attendance: Gilda Arreguin, Ernestina Escareno, Sandra Naylor Goodwin, Shelly Mitchell, Diana Ramos.

OWH Staff in Attendance: Tinah Concepcion, Jonelle Chaves, Zipora Weinbaum, Christina Florente, Leslie Holzman, Terri Thorfinnson

CDHS Staff: Sandra Shewry, Stan Rosenstein

Guest: Amber Hsaio

Call to Order and Introductions

Beatriz Solis, Chairperson, called the meeting to order at 9:50 a.m.. Council members announced themselves through a brief introduction and each shared something positive happening in their life.

The minutes from the May meeting of the Council were unanimously approved by the members.

Director's Remarks

Director Shewry welcomed Karen Dalton and Marty Jessup, the newest members of the Council, to the group. Karen Dalton shared that she was encouraged to join the Council to represent the microcosm of public health issues within women inmates. She is a Certified Jail Manager and Certified Health Education Specialist. Dr. Jessup's current research is focused on health issues among women with alcohol and drug problems and she is interested in the legal and ethical treatment of women.

Director Shewry then shared information on departmental activities. The Legislature completed a two year session in August. The Department's role in legislation is to make recommendations to the Governor on legislative issues related to health. As a result, the Department submitted 140 enrolled bill reports. In addition, the Department proposed legislation this year related to the departmental reorganization. Included in the language of the legislation is the reporting relationship of the OWH to the Directors

of both the Department of Public Health and the Department of Health Care Services (DHCS). The Council will be staffed organizationally with the OWH in DHCS.

SB 437, Escutia. This legislation is related to a pilot program for Medi-Cal eligible self-certification for two counties which have not yet been identified. If the pilots are successful there is language in the bill giving the Department the ability to implement the pilot statewide. Adele James recommended beginning discussions now for implementing an evaluation process in collaboration with foundations. Adele is willing to begin discussions and point out potential partners for the Department.

SB 739, Speier. This bill establishes a task force of infection control experts and medical doctors. The task force recommendations/consensus report recommended that process measures (i.e. does the hospital document that best practices are always adhered to?) be reported to the Department, not outcome measures. The Legislature gives authority to move towards outcome measures in the future. The Governor signed the legislation and it will be included in the Governor's budget with enforcement provisions.

SB 132, Alquist. Through this legislation the Department has been given authority to hire 150 new nurse facility evaluators, which will enable CDHS to enforce nursing home laws.

SB 1379, Perata. This legislation proposes looking for the presence of chemicals in bodily fluid and tracking the presence of chemical contaminants. The data gathered through the process will enable the State to look at the demographics of California population and will allow us the ability to use the Center for Disease Control and Prevention database. There are ethical considerations related to the survey participant's right to know if contaminants are found, which is addressed in the bill. Council member Adele James addressed the desire of the capacity to look at results of the study within differences between rural and urban areas. Many chemical contaminants are found in rural areas due to abandoned mines, etc. Although the Governor vetoed this bill last year, the revised bill is more in line with the feds. Questions were raised whether this would follow California Health Interview Survey (CHIS) participants or whether it included contaminants from meth lab dumping. Martha Jessup brought up the need to look at meth lab waste dumping into water sources and the impact on people "downstream." It is unknown how the toxic meth water affects health.

SB 1555, Speier. Expands prenatal screening, and adds new tests and markers. The bill proposes methods to increase the accuracy of existing prenatal tests offered through Medi-Cal.

SB 1755, Chesbro. Adult day health centers. Payment errors for adult day health centers are the highest out of Medi-Cal paid benefits. The feds have told the State to stop paying 80% of what is paid to adult day health care providers. This legislation addresses the issue by unbundling services, reforms the adult day health care program

to guarantee fair payments for providers, and simplifies eligibility for those frail elderly who need medical care in their home.

AB 2911, Nunez. Prescription drug program. Identifies framework for pharmaceutical manufacturers to voluntarily offer discount prescriptions. After a 3 year period if a manufacturer has not made discounts available, CDHS can eliminate the manufacturer as a prior authorized drug provider thru Medi-Cal.

The Director was asked for her perspective and the public health perspective of the Kuehl universal health care bill which proposes a health care system delivered by State, drastically changing the organizational infrastructure. Director Shewry indicated she is not sure the legislation received got the amendments and scrutiny it needed to make the best legislation. Did it serve a political purpose that sends a signal that things are broken? The Governor will veto this bill, similar to SB 2 pay or play proposition, since it only looks to one party, the State government, for the solution; instead, he feels that the government, employers, insurance companies, and individuals should all contribute and play a role toward a universal healthcare bill. The Governor has publicly stated he wants to make 2007 the year of health reform. The Governor is seriously concerned about the uninsured; it is not just coverage but also what can be done to reduce the trends in health care costs and personalized responsibility. Those that can put money towards the issue should. In addition, individuals have a responsibility to live healthy lives. Acknowledgement of that perspective comes with a sense that government has a policy role to play in making better choices easier for individuals. Council members should be involved in comprehensive care discussions. The insurance industry needs to ensure that a product is available regardless of preexisting conditions. California does not have insurance laws on books to administer a universal coverage offering.

Related to the impending organizational separation of CDHS, how does the administration create two organizations that do not then mirror the larger CDHS? Department incorporates visioning, talking with stakeholders about desires of needs from DPH and DHCS. What structure facilitates getting to an end result?

A certification of appreciation was presented to Luz Alvarez-Martinez acknowledging her resignation of membership on the Council and in thanks for her work with the Council. Luz was one of the founding members of the Women's Health Council when it was originally formed in 1994.

HPV Vaccine Panel & Discussion

Leslie Holzman gave an overview of HPV and cervical cancer rates in California. Cervical cancer is not the #1 killer, with 400 deaths in California annually. Overall, 10th most common cancer site for all California women; for Hispanics, 4th; Blacks, 7th; Vietnamese, 5th; and Koreans, 6th. HPV is one of the main causes of cervical cancer (types 16 & 18 cause ~ 70% of cervical cancers). HPV is the most common STD of which we are aware. Consistent condom use can reduce HPV by up to 70%.

The HPV vaccine, Gardasil, manufactured by Merck, prevents four types of HPV: 6, 11, 16 & 18. It will not protect you against any type you are already infected with. There is consensus that the best time to receive the vaccine is before girls are exposed. The current Advisory Committee on Immunization Practices guidelines target 11 and 12 year olds girls, but the vaccine is approved for females aged 9 to 26. The vaccine was tested in 33 countries on 20,000 individuals of all racial and ethnic backgrounds. But women with more than four partners were excluded from the trials (4 being used as the cut-off when a woman is more likely to have been exposed to HPV).

Currently the vaccine is being tested in males, but has not yet been approved. The vaccine is a three injection series, within a 6 month period. The cost of the vaccine is $120 per dose. It is not a live virus, so there is no fear of individuals contracting HPV from the vaccine.

The public health message must be that Pap tests remain as a standard disease detection procedure because the vaccine does not prevent all viruses which may cause cervical cancer. Efficacy is about 95% after only one dose. Three doses are necessary for long term efficacy.

Vaccines for Children (VFC) eligible patients will have access to free vaccines for eligible children under the age of 19. There are currently 4,600 active VFC providers in California. The HPV vaccine is not yet available through VFC. Feds are hoping to contract within the next month to obtain the vaccine and indicate the vaccine will be available in California before the end of the calendar year. Currently only the PPO's of the following health insurance compares are covering the vaccine: Health Net, Blue Cross, and Blue Shield. Kaiser is the only HMO that is covering the vaccine.

Alina Salganicoff discussed the financing issues of the vaccine. This vaccine is among the most expensive vaccines that is available, for both insurers and public programs. Some calculations indicate the vaccine is cost effective to prevent cervical cancer, however, only 4% of the estimated savings comes from preventing cervical cancers. The remainder of the savings is based on estimates accumulated by the cost of reducing the number of abnormal paps, colposcopies, etc.

Many up to 18 year old girls will be covered through VFC. One fourth of girls will be covered through VFC. Questions that we need to ask are what are the co-pays, what are the deductibles? The issue of legislative mandates will be controversial. There should be State level decisions and discussions on whether a mandate is imposed. No structured financing stream for 19 to 26 year olds. One fourth of 19 – 26 year olds are uninsured, and 44% of that age group throughout the state have employment based coverage. Of 19 to 26 year old girls in California, 1/3 of low income women are uninsured. The issue of co-pays and deductibles within low income women are going to be large issues.

Whether Title X coverage can be used to cover the HPV vaccine needs to be determined. The Merck Vaccine Patient Assistance Program has so far not been

interested in negotiating with clinics and the public, making it difficult for low income uninsured women to get the vaccine. These women can only obtain the vaccine if they go to a private doctor that is already administering Merck vaccines.

Tracy Weitz. She advised to proceed with caution with respect to this vaccine. The vaccine has proven to provide protection for 5 years, but until studies have gone on longer, it is unknown how long the vaccine will work. Will booster shots be necessary along the way to ensure protection level is at full benefit? High grade pap smears, not statistically significant difference between the 2 groups. Not sure how long between original vaccine and boosters. Who dies from cervical cancer? Many women that are now dying are women that have never had a pap smear. It is important to realize that within immigrant populations those women are not in the current cycle of pap smears, and would not be in the cycle to receive vaccines. Reality of public health dollars is that there is not enough funding for current services, to add on an expensive vaccine. Who is benefiting – massive amounts of money from fed and state government to pharmaceutical companies - $360/series plus possible booster shots to a sole manufacturer?

Women need to be offered a choice, as women advocates that is what we should be promoting. Best thing that the State can offer now is education so that women will know what choices and options are available.

Following the presentations, one of the initial comments indicated skepticism about statistics. In the women's health community, there is a tradition of skepticism – more is not necessarily better. We need to ensure we proceed as a voice of caution – cervical cancer still needs attention and we need to push for answers to the unknown. What are some of the outreach mechanisms for special populations? The CBO's are not fluent in health. In terms of data, it comes from CHIS. What kind of information do we want to provide to the women of California on this issue? We need to weigh our decision on whether to support the vaccine outside of the VFC recipients, but we may also need to make a decision about resource allocation. Time is not our enemy on this issue, there is not an immediate urgency.

Medi-Cal DRA Immigration

Stan Rosenstein indicated that Medi-Cal is currently in the process of looking at coverage of HPV vaccine at the present time. The State perspective for VFC is that the vaccine is very affordable. However, outside of that population, questions are being asked by the administration regarding services. If we do fund the vaccine, something else may not be funded. Stan welcomed comments from the Council by November on recommendations for the vaccine. Stan feels it is very important that the WHC weighs in on the decision.

Stan addressed Emergency Contraception, Plan B availability through Medi-Cal and Family PACT. Both will cover it. However, Stan cautioned that many insurers will no longer cover it through insurance because of the availability of the drug over the counter, which means an increased cost to the consumer for the full price over the

counter. Protocols are being developed by CDHS which will be shared for input/comment.

The Family PACT waivers issues have not yet been decided. Beyond the Deficit Reduction Act (DRA) policies, the feds are attempting to demand qualification/eligibility criteria. Currently the application process in California is online. Family PACT is a premier program for family planning in the nation. We are in the process of addressing a broader package with feds. The issues being addressed related to Family PACT are much larger than just DRA. The waiver has been extended through November 15. The feds have major issues with eligibility for the program in California. California is committed at the highest levels of the Administration to continue broad access to care in family planning services.

Council members asked Stan about Medi-Cal coverage for digital mammography, and indicated the supply of providers must be far greater. Stan informed Council that Medi-Cal is very close to issuing a policy covering digital mammography.

DRA - As background, Congress passed as sweeping change a little known provision which was effective July 1, 2006. The new policy indicates new applicants to Medicaid must provide proof of citizenship. The federal government now mandates states ask for documentation in order to be reimbursed. The federal regulations are specific. In addition, recently passed state legislation now requires proof of citizenship as a condition of eligibility. CDHS will allow as much flexibility as possible for providing documentation as proof of citizenship. CDHS forwarded a draft implementation policy to statewide stakeholders. Over 1500 organizations/individuals submitted comments to the draft All Counties letter. The final draft letter will be shared at a stakeholder meeting one last time prior to distribution.

Current recipients of Medi-Cal (not SSI, not MediCare) must provide proof of citizenship at the time of annual redetermination. Undocumented and illegal immigrants are not affected by this policy. Blind individuals have an unlimited time to obtain documents; however, no benefits are received during the waiting period. Federal rules indicated that current enrollees have an unlimited amount of time to obtain information to prove citizenship at the time of redetermination. Individuals not currently enrolled are not eligible for Medi-Cal until proof of citizenship is provided. Children under the age of 16 can have a parent verify their eligibility. The State is currently attempting to perform vital statistic matches on all applicants. Foster children are eligible as long as a good faith effort is being made to obtain proof of citizenship. Individuals which are incarcerated for an extended period of time have benefits suspended. Upon release, unless they are able to prove citizenship, they will have difficulty reenrolling.

Per Stan, babies born to mothers on Medi-Cal are automatically given one year of full coverage. The current process has been to transition those babies to Medi-Cal after being deemed for one year. New prohibitions prevent deeming for those children. After one year the child must apply for continued coverage as a new enrollee. The State cannot grant deemed eligibility for babies of undocumented mothers, they will no

longer be automatically qualified. The State is negotiating with feds on this issue and trying to do what is right in California. Presumptive eligibility programs are exempted. Emergency benefits are available to those not able to prove their citizenship, only within California. These regulations apply to drug Medi-Cal also.

There is concern over the cost of implementing the requirement. California does not know how they will be covering costs. States are given the ability to transfer money from Medi-Cal program line item services to pay for services provided by counties to implement the program.

Council members are concerned about the lack of an educational campaign and social marketing. The State has determined not to put the word out yet, a strategic decision until specifics have been determined. Stan encouraged the Council to provide assistance on messaging for outreach, which must come from the community level. If you are a citizen and recipient of Medi-Cal, it affects you. In many ways it changes how we do outreach.

What are the tasks for the State right now with communication with the counties? The State has determined the best way to handle the issues are in prescriptive communications with counties. Medi-Cal is working closely with the County Welfare Directors Association. The counties have received a copy of the draft All Counties letter. Council members asked for clarification on the issue of providing an affidavit for individuals that may not be able to obtain proof of citizenship, such as the homeless population. Individuals verifying citizenship of an applicant through an affidavit must be a citizen. Undocumented parents can verify citizenship for their children if they are born here. The status of the parent's citizenship is not relevant. This policy will begin being implemented this Fall.

Concerns have been raised related to the impact of the implementation of this policy on the elderly population. Those on Medicare are exempt; however 15% of the elderly population which are not Medicare recipients are affected. This group will probably use affidavits.

Working Group Updates

Immigration Working Group Update: The combination of the Immigration & Medi-Cal working groups has not yet been decided. OWH staff informed Council members that input to the DRA implementation is important to the Department. Stan has represented the Department and is receptive in obtaining input. OWH staff reminded members it is important to have full participation in working groups in order to submit input to the Department. The Immigration Working Group submitted a response to Medi-Cal to the draft All Counties letter. A copy of the All Counties letter as well as the letter from the working group is included in the packet.

Mental Health/Substance Abuse Working Group Update: One of the questions being addressed is where to get services and where the gaps are? There is a need to utilize

a gender perspective during the funding cycles. The group will prepare a letter to reiterate importance of the gender lens.

CDHS Reorg Working Group: Final recommendations of the Council are included in the recommendations of the Department. The working group recommendations were forwarded to the Director. The Council had a preference for being placed in DHCS. The administration respected the wishes of the Council and placed OWH in DHCS. In addition, the legislation places OWH in the Director's office of each department in statute, to ensure future reporting relationships. The implementation of the reorganization will be the next issue for the working group to discuss.

OWH Update

The Council was informed the office was interested in giving them an opportunity for input into policy. The OWH will be developing a state strategic plan, assessing recommendations for an action plan or agenda related to women's health and wanted to know how to involve advocacy groups. The OWH asked if the plan should be used as guiding principles for policy makers around women's health. Council members indicated the California Partnership for Women's Health Care group produced similar guidelines a couple of years ago. Mary Wiberg indicated she would provide a copy of guidelines prepared by the California Primary Care Association's group to the Council for consideration. OWH would like to know how to incorporate women's health agendas into the Department, and how to integrate within the Departmental infrastructure.

In the early years, the Laurie Drabble days, there was a general strategic plan prepared by the Council. The Council members may like to take a look at it and reshape it to meet current needs to include access, treatment and prevention in all women issues.

Council members stated they would like to include the overarching issue of racism within an action plan. They also recommended reviewing the Institute Of Medicine model of a strategic plan as a good model to use. The Women's Foundation put together hearings, similar to Commission on Status of Women hearing in lieu of a strategic plan.

Mily shared that Lideres Campesinas holds convenings every two years to obtain direct input from 250-300 immigrant women. A facilitator conducts focus groups and the proceedings are documented by experts and a report is produced. This process helps Lideres determine whether the group is responding to local issues or not, and the documentation produced is helpful in evaluating activities. As an example, there were four groups formed to discuss issues of domestic violence – how it affects health, work, family and culture. Each group's proceedings was documented and attended by an expert. The reports compiled as a result of the convenings were useful in talks on funding. Mily will provide copies of reports of the convenings to the OWH and extended an invitation for next year's convening.

The Council would like to see us develop a strategic planning process (how to choose subjects, how to integrate groups), not a strategic planning document. There was

general concern that members may fall victim to the process if they feel they are doing something by planning, instead of planning on doing something. Council members do not want to pretend we are doing something which does not then develop into action.

There is credibility in the development of guiding principles that enhances the Council, and the Office. There is value to the Council in staff developing something the Council can respond to and cautioned OWH to keep the principles statement very focused.

Basically, the group shares the same values (some will disagree), but staff are encouraged to do the dance – lead, follow, lead, follow. But with a group this size, it is hard to respond.

Council members would like to see continued participation in the human trafficking task force. There is a need to identify gaps, track the victim's perspective, post traumatic stress, the delay in access to services, and address the lack of linguistic services in mental health. There is pending legislation that expands benefits to human trafficking victims. The OWH is not sure if the Governor will sign or not. The Governor is looking to task force for recommendations within the next year. Human trafficking continues to be a priority of the Director to participate in the task force.

Emerging Issues

HPV Vaccine – must be a working group. Members of the Working Group include: Alina Salganicoff, Tracy Weitz, Ruth Holton Hodson, Ellen Eidem, Yali Bair, Jane Zones, Crystal Hayling, Karen Dalton.

Summary of discussion related to an HPV vaccine recommendation:

- Need to further determine impact of vaccine before implementing.
- Mixed feelings because it is supportive of something offered to women, of which there are not enough choices. Would support because women should have a choice in their own health care options.
- Issues related to inequity are biggest concern because of lack of choice between haves and have nots.
- Push for information and outreach to empower good outreach, but issue of inequity trumps all.
- Needs to be made available, so women have options.
- Equity is major issue. Contextualize it within commitments of what other services need to be continued to be performed.
- Primary concerns are access, equity, informed decision.
- Two tier issue and access. Co-location model for service delivery. Concern for lack of equity issues with an offering being made to California women that are not available to women in other countries, where cervical cancer rates continue to be high.
- Somewhat mystified it has gotten as far as it has, now in a place that we can respond as best as we can. Those with least access can get it.

- Loud clear voice. Unbiased educational materials and provided choices are the keys. Cannot rely on Merck to provide the educational component. No mandates, choice only.
- A lot of concerns about the science and the sole source arrangement.
- Do not believe we should support. Concerned that if the standard is population based health, it means that other services would be cut. Science has proven that Pap smears are the efficient way to diagnose cervical cancer.
- Concerns with trying to get the public health community to do the PR work for pharmaceutical companies. Girls 19 – 26 year olds have probably already been exposed and the efficacy is diminished. Not sure it is the best public health service to be offered in lieu of others.
- Cannot serve anyone if we cannot serve everyone.
- Access, levels of access. Cost of care for cervical care.
- Concerned with follow-up and lack of efficacy if the three vaccines are not available.
- Opposes vaccine.

Emergency Contraception, Plan B – access to care, protocol to respond to Medi-Cal. Members of the Working Group are: Golnaz Agahi, Yali Bair, Ruth Holton Hodson, Ellen Eidem.

Breastfeeding – encouragement, State policy development. Few state groups without a commercial interest in formula industry. An independent voice to issue. Gail Newell, Sarah Samuels, Catherine Quinn. Sarah will check with Laurie True.

Nutrition/Exercise – State work site elements.

Domestic Violence (DV) – Incorporating primary prevention in DV issues. Violence Against Women Act (VAWA) was reauthorized with a new section of language re: VAWA Prevent. The holding place for activities. Primary prevention is going to look different in California than it will look anywhere else in the nation. Namju Cho and Mily Trevino Sauceda will contact VAWA and invite to present at Council meeting.